APPENDIX E

NHDS Medical Abstract Form

Form HDS-1

OMB No. 0920-0212: Approval Expires 08/31/2005

FORM **HDS-1**
(3-27-2003)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

MEDICAL ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. PATIENT IDENTIFICATION

1. Hospital number . . . . . ☐☐☐☐

2. HDS number . . . . . ☐☐☐☐

3. *(Item deleted)*

4. Date of admission . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

5. Date of discharge . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

6. Residence ZIP Code . . . . ☐☐☐☐☐

B. PATIENT CHARACTERISTICS

7. Date of birth — Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

8. Age – Complete only if date of birth not given — Units ☐☐☐
1 ☐ Years
2 ☐ Months
3 ☐ Days

9. Sex – *Mark (X) one*
1 ☐ Male 2 ☐ Female 3 ☐ Not stated

10. Ethnicity – *Mark (X) one*
1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 3 ☐ Not stated

11. Race – *Mark all that apply*
1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian
5 ☐ Native Hawaiian or Other Pacific Islander
6 ☐ Other – *Specify*
7 ☐ Not stated

12. Marital status – *Mark (X) one*
1 ☐ Married 3 ☐ Widowed 5 ☐ Separated
2 ☐ Single 4 ☐ Divorced 6 ☐ Not stated

C. ADMINISTRATIVE INFORMATION

13. Type of Admission – *Mark (X) one*
1 ☐ Emergency 3 ☐ Elective 5 ☐ Items not available/ unknown
2 ☐ Urgent 4 ☐ Newborn

14. Source of Admission – *Mark (X) one*
1 ☐ Physician referral
2 ☐ Clinical referral
3 ☐ HMO referral
4 ☐ Transfer from a hospital
5 ☐ Transfer from SNF
6 ☐ Transfer from other health facility
7 ☐ Emergency room
8 ☐ Court/Law enforcement
9 ☐ Other – *Specify*
10 ☐ Item not available

15. Status/Disposition of patient – *Mark (X) appropriate box(es)*

Status	Disposition
1 ☐ Alive	**a.** ☐ Routine discharge/discharged home
	b. ☐ Left against medical advice
	c. ☐ Discharged, transferred to another short-term hospital
	d. ☐ Discharged, transferred to long-term care institution
	e. ☐ Other disposition/not stated
2 ☐ Died	
3 ☐ Status not stated	

16. Expected source(s) of payment

	Principal *Mark one only*	Other additional sources *Mark all that apply*
1. Worker's compensation	☐	☐
2. Medicare	☐	☐
3. Medicaid	☐	☐
4. Other government payments	☐	☐
5. Blue Cross/Blue Shield	☐	☐
6. HMO/PPO	☐	☐
7. Other private or commercial insurance	☐	☐
8. Self pay	☐	☐
9. No charge	☐	☐
10. Other – *Specify*	☐	☐
☐ No source of payment indicated		

(Over)

D. MEDICAL INFORMATION

17. Final Diagnoses (including E-code diagnoses) (Enter ICD-9-CM codes as well as narrative if available)

Principal: _____

Other/additional: _____

18. Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as narrative if available)

	Date of procedure(s)									
	Month		Day		Year					
Principal: _____										
Other/additional: _____										

☐ NONE

Completed by	Date